October, 2003

Dear Employee:

Your care and the care of your dependents are important to HealthSelect.

Please take time to complete the form on the reverse side so that we can assure that any on-going medical needs smoothly transition to your new HealthSelect program for you and your family members.

Special medical conditions may include: high risk pregnancy or third trimester pregnancy, organ or tissue transplantation services which are in progress, chronic illnesses such as diabetes, congestive heart failure, chemotherapy/radiation therapy, durable medical equipment , oxygen, and home health services.

With Open Enrollment closing November 3rd, it is important that you provide all requested information as soon as possible so we may assist with any arrangements for the changeover of care and treatment.

Count on us to care!

HealthSelect Customer Service
(602) 344-8760, TDD Line: (602) 344-8789

(See Reverse Side for Form)

Return Completed Form to:

HealthSelect
Attn: Membership/Member Relations Coor.
2502 East University Drive, B-125
Phoenix, AZ 85034
Customer Service: 602.344.8760

Or Fax to:

Fax: 602.344.8752

HealthSelect
MEDICAL CARE TRANSITION BENEFIT REQUEST

The Employee should complete this form.
(Note: The nature of the medical condition being considered for transition may require that HealthSelect request information from the treating physician. HealthSelect will contact you if additional information is needed.)

Effective Date of HealthSelect Coverage: JANUARY 1, 2004

Employee Name:

Employee Address:

City: State: ZIP:

Employee Social Security Number
(or Alternative ID for Employee):

Employee Date of Birth:

Employee Work Telephone:

Dependent Full Name (If Applicable):

Dependent Address:

City: State: ZIP:

Dependent Social Security Number
(or Alternative ID for Dependent):

Dependent Date of Birth:

Relationship to Employee (If Applicable):

Is the current insurance company covering the services you are requesting to be transitioned? YES NO

HealthSelect Primary Care Physician Selection:

Reason for requesting continued treatment by the current provider:

Employee Name:
Employee ID# Patient Name:

HealthSelect
MEDICAL CARE TRANSITION BENEFIT REQUEST

This Section To Be Completed By Treating Physician

Name of treating Physician:

Address of treating Physician:

Telephone #: Fax #:

Diagnosis including ICD-9 codes and description of illness or injury:

Date of diagnosis:

Treatment Plan: Attach additional information as necessary

Duration of treatment:

List any medications patient is using:

Physician Signature: Date:

To Be Signed By Patient or Guardian

I hereby authorize the above physician(s) to provide HealthSelect and Maricopa Integrated Health System with any and all medical records relating to the above-mentioned diagnosis and treatment for HealthSelect and Maricopa Integrated Health System's use in evaluating my request for medical care transition. This Authorization is valid for 6 (six) months from the date signed below.

Signed by Patient or Guardian: Date:

Return Completed Form to: HealthSelect
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Customer Service: 602.344.8760

Or Fax to: Fax: 602.344.8752